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THE EXTRAPERITONEAL TREATMENT OF THE STUMP IN ABDOMINAL HYSTERECTOMY FOR UTERINE MYOMATA.

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Any method which is safe, avoids prolonged shock, and is accompanied with good results should be welcomed in the removal of large uterine myomata. For ten years I have watched with interest the best-known gynecological operators in the various methods of removing uterine myomata. We have practiced about all the methods in vogue. But in the removal of large uterine myomata with debilitated patients shock is generally profound. Such patients nearly all possess deficient heart or deficient kidney action, the very organs of most vital importance. Some six months ago Dr. N. Senn invited me to witness a method which he had devised to remove a uterine myomata, producing an extraperitoneal stump. In June and July Dr. Lucy Waite and I tried the method on two large myomatous tumors with such gratifying success that I am induced to report the results.

Mrs. A., from Wisconsin, a physician's sister, came to us for the removal of a large uterine myoma. A long median incision was made to allow the tumor to be brought out of the wound. Now with catgut, beginning at the angle of the wound above the umbilicus, the peritonæum was closed down to the posterior surface of the uterus. We then ligated with catgut the ovarian arteries at the fimbriated ends of the Fallopian tube, and a large clamp was placed on the broad ligaments on each side of the uterus as far down as we wished to begin to make the peritoneal cuff. We then split the broad ligament down to the uterine arteries, and ligated them with catgut. The peritoneal cuff is now stripped down, mak-

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ing as ample a cuff as possible. The uterus is amputated just above the internal os. No bleeding follows, only oozing, as we have ligated both ovarian and uterine arteries. We now suture the upper edge of the peritoneal cuff to the parietal peritoneal edge, which was produced by the median incision, and the peritonæum is entirely closed. We can close the peritonæum immediately after making the cuff if desired, in which case the shock is simply similar to an exploratory laparotomy. The stump is drawn up in the wound and fixed there. The external layers of the abdominal wall, muscles, fascia, and skin are then closed by silkworm-gut suture. The two sutures in the wound over the extraperitoneal stump are allowed to remain untied for thirty-six to forty-eight hours to allow the escape of primary wound secretion. The patient made a recovery with little pain or discomfort.

Dr. Simmons, of Tomah, Wis., called us to operate in his hospital on Mrs. B., who had had a large uterine myoma for years. Dr. Lucy Waite and I, with Dr. Simmons' assistance, performed the extraperitoneal method, as in the case of Mrs. A. The patient made an excellent recovery. In both of these cases we drew the ligated ovarian arteries with the ligatures into the wound with the extraperitoneal stump. This procedure left no ligature in the abdominal cavity; all were extraperitoneal.

The advantages of the extraperitoneal treatment of the stump in abdominal hysterectomy for uterine myomata are substantial and valuable.

1. The method of immediate closure of the peritoneal cavity as soon as the tumor is rolled out avoids shock to a wonderful degree. In our last two cases we finished the operation of removing large uterine myomata with a pulse of 85 to 90.

2. After drawing out the tumor and closing the peritoneal cavity with the posterior peritoneal cuff, one can proceed as leisurely as the case demands, for in reality the abdomen is closed.

3. The hæmorrhage which might follow could be arrested without endangering the peritoneal cavity.

4. We can do the operation without leaving a single arterial ligature in the peritoneal cavity. I had often previously made large cuffs in uterine myoma and ligated the uterine arteries extraperitoneally, splitting the broad ligaments, and also put Kleeburg's elastic ligature around the uterine stump, stripped of its peritonæum, and sewed the peritonæum to the abdominal wall to close the peri-

toneal cavity, but I had never followed a distinct plan of immediately closing the peritoneal cavity as soon as the tumor was rolled out, until suggested by Professor Senn.

5. The pelvic floor is not weakened by removal of the cervix.

6. Very weak patients will be able to bear this operation, as the shock is remarkably slight. In making the posterior flap or cuff one must be careful not to cut below the peritonæum, or some troublesome hæmorrhages may arise.

